Preferred Provider Network (PPN) License Instructions

Effective October 1, 2003, Public Act 03-169 revised Connecticut General Statute § 38a-479aa to require Preferred Provider Networks (PPNs) offering services in the State of Connecticut to be licensed. The State of Connecticut Insurance Department (the Department) is charged with licensing PPN entities. If you have any questions about your responsibility to be licensed, please refer to CT Public Act 03-169 on the legislative pages of the state website at www.ct.gov [http://www.cga.state.ct.us/2003/act/Pa/2003PA-00169-R00SB-00917-PA.htm].

Instructions:

○ **All PPNs must be initially licensed by the later of 1) May 1, 2004, or, 2) prior to doing business in Connecticut, and must renew such license each May 1st thereafter. This application and all attachments must be returned to this Department by March 1st (or at least two months prior to the date the PPN license is required). If your network meets the guidelines for licensure, an invoice for the license fee of $2500 will be forwarded to you. This invoice must be paid prior to the license effective date.**

○ **The application must be filled out, completed, and signed by the CEO of the PPN entity certifying that all information provided is true and accurate.**

○ **Submit application and attachments to:**

State of Connecticut Insurance Department
Life and Health Division
P O Box 816
Hartford, CT 06142-0816

***Hand delivery or Overnight delivery address ONLY*:**

153 Market Street, 7th floor
Hartford, CT 06103

DO NOT SUBMIT THE LICENSE FEE WITH THIS APPLICATION. You will be billed.

Once licensed, the law requires the PPN to submit quarterly and annual financial reports. To comply, please refer to P.A. 03-169 and forward those reports to the Department at the address above.

Preferred Provider Network (PPN) License Application

Name of PPN:_____

PPN Business Address:_____

_____

_____

PPN Mailing Address (if different): _____

_____

_____

PPN Phone Number: _____

<u>Contact Information (used by the Department for all future correspondence)</u>:

Name:_____ **Title:**_____

Mailing Address:_____

_____

_____

Phone number:_____ **FAX number:** _____

E-mail address:_____

Does your PPN provide services for workers' compensation <u>only</u>? [ ] NO [ ] YES

<u>If YES,</u> you are *not required* to complete this application. Please return this page and the signed CEO Certification (page 7) to the Insurance Department at the address on the Instructions page**.**

Name <u>and description</u> of controlling company or organization: _____

_____

_____

Controlling company's or organization's contact name: _____

_____

Business Address: _____

_____

Mailing Address (if different): _____

_____

Name of related or predecessor controlling company or organization:

_____

Address: _____

_____

_____

Explain current relationship with related or predecessor controlling company:

_____

_____

_____

_____

Has any suspension, sanction or disciplinary action been taken against the PPN in Connecticut or any other state?

[ ] No

[ ] Yes If yes, explain: _____

_____

_____

_____

_____

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state?

[ ] No

[ ] Yes If yes, explain: _____

_____

_____

_____

_____

Describe the PPN's service area: _____

_____

_____

How many total enrollees are served by the PPN: Nationwide:_____in CT:_____

List participating hospitals in Connecticut:

_____
_____
_____
_____

Name and address of the person to whom applications may be made for participation:

_____
_____
_____

List all entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees (e.g. Managed Care Organizations):

_____
_____
_____
_____

Indicate the type(s) of reimbursement arrangements that the PPN enters into <u>with entities on whose behalf the PPN has contracts or agreements to provide health care services</u> to Connecticut enrollees (e.g. Managed Care Organizations):

[ ] Capitation
[ ] Fee for Service
[ ] Other -- Please explain: _____
_____

Indicate types of services that the PPN provides for <u>entities on whose behalf the PPN has contracts or agreements to provide health care services</u> to Connecticut enrollees (e.g. Managed Care Organizations):

[ ] Medical services
[ ] Utilization Review – if checked, your CT License Number:_____
[ ] Claims administration
[ ] Dental Services
[ ] Other – List types of services

_____
_____

Indicate type(s) of reimbursement arrangements that the PPN enters into <u>with participating providers:</u>

[ ] Capitation
[ ] Fee for Service
[ ] Other -- Please explain:_____
_____
_____
_____

PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:

[ ] Certificates from the Secretary of State affirming that the PPN and its controlling company or organization (if applicable) is in good standing in the state. For out of state PPNs, controlling companies or organizations, a certificate that such PPN, controlling company or organization is in good standing in its state of organization.

[ ] A list of the names, official positions, and occupations of members of the PPN's board of directors or other policy-making body and those executive officers who are responsible for the PPN's activities with respect to the health care services network.

[ ] A list of the names, official positions and occupations of members of the controlling company's or organization's board of directors and those executive officers who are responsible for the controlling company's or organization's activities with regard to the health care services network.

[ ] A list of the PPN principal owners.

[ ] A list of the controlling company's or organization's principal owners.

[ ] A list of participating primary care physicians, the specialty physicians and other providers, including the number and percentage of each group's capacity to accept new patients.

[ ] A description of the general criteria for selection and/or termination of providers.

[ ] A list of subcontractors of the PPN that provide health care services to Connecticut enrollees and assume financial risk from the PPN; and to what extent each assumes risk. This does not include individual participating providers.

[ ] A table of all major categories of health care services provided by the PPN.

[ ] A contingency plan describing how contracted health care services will be provided in the event of insolvency.

[ ] Proof that the PPN meets minimum security standards as defined in P.A. 03-169(i). Proof can be in the form of a letter of credit, bond, surety, reinsurance, or reserve exclusively held for "…use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment…".

[ ] The most recently concluded fiscal year-end financial statements for the PPN
AND
[ ] The most recently concluded fiscal year-end financial statements for the controlling company or organization.

- **If the last fiscal year-end financial statements (for the PPN and the controlling company or organization) ended more than 90 days prior to your license application date, you must also include an internally prepared financial statement (using GAAP) for the quarter ending within the 90 days prior to that date. The next fiscal year-end financials must be sent to the Department within 120 days of your fiscal year-end.**

- **Financial statements must be "Reviewed" or "Audited" by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP).**

- **The law requires that a PPN maintain a minimum tangible net worth of the greater of $250,000, or, an amount equal to eight percent (8%) of annual expenditures as reported on its most recently filed financial statement. To determine tangible net worth the Department requires that your financial statements be prepared using GAAP and the net worth be adjusted to exclude intangible assets, which include but are not limited to, goodwill, patents, deferred costs, deferred tax assets, franchises, licenses, trademarks, trade names, copyrights, service marks and brand names. For purposes of this reporting "expenditures" are the expenses or costs incurred by the PPN to maintain the network. <u>SUBMIT THE WORKSHEET ON PAGE 7 TO EXPLAIN HOW YOU DETERMINED THE MINIMUM AND ACTUAL TANGIBLE NET WORTH OF THE PPN.</u>**

[ ] Provide the names and addresses of the public accounting firm and internal accountant(s) which prepared or assisted in preparation of such financial statements.

Preferred Provider Network
Financial Requirement Calculations

Calculation of Minimum Tangible Net Worth:

Minimum tangible net worth shall be the greater of (A) $250,000, or, (B) 8% of the PPN's annual expenditures (as reported on its most recently filed financial statement). Please calculate your minimum tangible net worth requirement below:

Calculation of Actual Tangible Net Worth:

Net Worth from the most recently concluded fiscal year-end financial statements: $_____

Less Intangible Assets:

$_____

Total Intangible Assets _____

Actual Tangible Net Worth $_____

Calculation of "Financial Security":

This amount shall be at least an amount equal to the greater of (1) an amount calculated on the basis of the two quarters within the past year with the greatest amounts owed by the PPN to participating providers, or, (2) the actual outstanding amount owed by the PPN to participating providers.

Please calculate the amount of your required "Financial Security" below:

Each contract between this preferred provider network and its participating providers contains a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

[ ] YES [ ] NO

CEO CERTIFICATION OF ACCURACY

I, _____, _____of
(Printed Name) (Title)

_____, hereby certify that
(Preferred Provider Network)

I have reviewed the information submitted in accordance with Connecticut General Statutes Section §38a-479aa as revised by Public Act 03-169, and that the information is true and accurate. I understand that any material modification of any matter or document furnished pursuant to this application must be filed with the Insurance Commissioner within thirty (30) days of such modification, including supporting documents to explain the modification.

_____ _____
(Signature of CEO) (Date)

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